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IN THE CIRCUIT COURT OF
THE 11TH JUDICIAL CIRCUIT
IN AND FOR DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO. 94-08273 CA (22)

HOWARD A. ENGLE, M.D.,
et al.,

Plaintiffs,

vs.

R.J. REYNOLDS TOBACCO
COMPANY, et al.,

Defendants.
_____/

Miami-Dade County Courthouse
Miami, Florida
9:30 a.m.
October 28, 1998

TRIAL - VOLUME 111

The above-styled cause came on for trial before the Honorable Robert Paul Kaye, Circuit Judge, pursuant to notice.

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On behalf of Plaintiffs

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and Brooke Group

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On behalf of Defendant Brown & Williamson
JAMES T. NEWSOM, ESQ.
On behalf of Defendant Lorillard

DEBEVOISE & PLIMPTON
ANNE COHEN, ESQ.
JOSEPH R. MOODHE, ESQ.
On behalf of Defendant The Council for Tobacco Research

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(APPEARANCES - Continued)

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On behalf of Defendants Liggett Group
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(Whereupon, the following proceedings were had:)

THE COURT: All right. We have all the jurors. We're all set. Let's bring the jury out.

(The jurors entered the courtroom.)

THE COURT: Good morning, folks. How are you all today?

Doctor, if you'll resume the stand.

DIRECT EXAMINATION (Continued)

BY MR. ROSENBLATT:

Q. Okay. Dr. Staples, in terms of performing transplant surgery, either with a new heart or a new lung, does that take place only after conventional medical therapies are found not to be useful anymore?

A. That's correct.

Q. And where, generally speaking, do the donor organs come from? Someone needs a new heart or needs a new lung, where and how do you them?

A. Donors are always unfortunate accidents of nature or of human device. And they're always tragic deaths of relatively young people under the age of 70 for kidneys and under the age of 55 for hearts and lungs.

But the types of mechanisms of death in donors are mainly auto accidents with head injury, gunshot wounds to the head, either homicide or suicide,

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and lastly what's called intracranial hemorrhage where a blood vessel bursts in the brain, it puts pressure, the blood puts pressure on the brain and then the brain dies.

So, universally, all of these people have what's called brain death, which is a legal definition of death, but not a physiologic definition of death. Everything but the brain is alive in those patients.

Q. Overall, in terms of recent developments in the field of transplantation, both heart and lung, how do these patients who receive a heart or lung from someone else, how do they do?

A. They do really well. It's by far the most satisfying work that I perform; to take a patient who's crippled from heart disease or lung disease and within days they are -- their bodies are really holding back their real ability to get back on their feet.

And as their bodies r r, I've had a double lung transplant who swam in the Transplant Olympics. There's a patient on the Board of Regents at the University of Florida who, before transplantation, was working on his computer as a legislative assistant and now works in Tallahassee and is doing miraculously well.

There are plenty of individual success

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stories. But as a group, over 50 percent of heart transplant patients live more than ten years. The statistics at the University of Florida for hearts are about 90 percent survive at one year, about 80 percent survive at two years, and then it slowly tapers off. The survival tapers off over the next ten years.

We've had patients who we transplanted in 1986 who are still alive for hearts. Lungs are a little bit less successful.

Q. In terms of the overall statistics?

A. In terms of success. It's about an 80 percent one-year survival. And it goes down. The five-year survival is roughly 50 percent. But those numbers are gradually increasing as time goes by, too, because we're getting better at it.

Q. There is a concept mentioned when you read about in a newspaper transplantations, this concept of rejection, tell us about that. The concept of the body rejecting a foreign organ.

A. Well, what you stated there is what we would all think about, medical people or not. The body does recognize its own self and can reject foreign tissue put into it. And sometimes it even rejects parts of itself, like in rheumatoid arthritis or lupus or other types of diseases, where the body tends to reject

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itself. But there is a process of rejection in all types of transplantation, and patients must be on drugs to suppress that.

Q. How long, in general, does heart transplantation surgery take from the time you begin, the patient is anesthetized, and from the time you start to do your work until you're done?

A. Well, the transplant procedure is really in two parts. One is on the recipient end, we work with him or her; and the other is the donor end. And we work with both individuals, our team does, so that if there's a donor, for instance in Miami, I will come and get that heart and take it out of the donor and then bring it back to my colleagues who are at the university who are preparing the recipient.

A heart transplant operation and a lung transplant operation can last as short as three hours. I've been in operations that have lasted as long as 20 hours. On the average, it's about a four to six-hour operation nonstop, standing right next to the patient.

Q. Now, the instance you gave where you would travel to Miami or anywhere to actually get the donor organ, you are personally involved in that surgery as well?

A. I'm doing it, yes.

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Q. You're doing it?

A. Yes.

Q. And then --

A. Or teaching it to be done.

Q. I assume there's some kind of method whereby the organ can be safely removed and preserved and taken to Gainesville?

A. We run a solution through it which cools it and preserves it. And then we put it in a sterile bag and we simply put that in a cooler and transport it by either helicopter, ambulance, we use jets to get in and out of Gainesville, because we only have about four hours from the time I take it out of the donor to the time blood is running through it and all the stitching is done in the recipient. I've got four hours to do that. That is, cut it out, transport it, put it in and get it working, four hours. And for lungs --

Q. What would happen, for example, if you couldn't do it in four hours, it took six hours?

A. After that period of time, the heart gets weaker and weaker and weaker. I can't say at four hours and fifteen minutes it's not going to work, but at four hours and a half, I might require large doses of drugs to keep it going or at five hours I might require a ventricular assist device to support it to

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allow it to recover.

Certainly neonatal hearts are more resistant to deterioration than adult hearts. So, some of the neonatal heart transplants that are performed for congenital heart disease can be transported over long distances and long times. And that's very complicated surgery.

Q. In babies?

A. In newborns.

Q. Newborns?

A. Newborns.

Q. So in terms of both -- in terms of the recipient, the person, the patient receiving the organ, from the standpoint of age, does it run the gamut from infants to elderly?

A. Yes.

Q. Now, obviously you're a thoracic surgeon, you're a cardiovascular surgeon. But prior to the surgery, after a determination has been made or even before, do you get involved in the treatment, making recommendations for the patient before the patient actually has his or her surgery?

A. Oh, absolutely. The patients are mostly hospitalized prior to their heart transplants, and they're hospitalized on the same floor that we have our

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surgery patients, so we see them very frequently. And if they become unstable, then we get very closely involved in making decisions about whether to go on artificial devices and things like that.

Q. And in connection with seeing these patients prior to surgery, do you actually get histories from them?

Is it important for you to be familiar with their histories?

A. Well, that process is done prior to approval for heart transplantation or lung transplantation. And very extensive histories are done by many different people, including myself, social workers, psychologists, chaplains, cardiologists, pulmonologists, interns, residents.

I don't know how the patients put up with it, frankly, but it's a long process and from a lot of different areas. And then we meet as a group to decide on whether this patient is acceptable for transplantation. Not only based on those interviews, but medical tests and things like that.

Q. In terms of the preparations, getting the patient in shape to receive the donor organ in terms of diet or -- I mean, what do you do, what are your standard recommendations to get the patient in the best

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possible shape to have the best possible result?

THE COURT: Counsel, maybe we ought to have a sidebar.

(The following proceedings were had at sidebar:)

THE COURT: Under ordinary circumstances, I wouldn't do this, but the doctor has a tight schedule this afternoon, and it seems to me that these questions are really outside the periphery of this Court's consideration of what we're talking about.

We're talking about smoking tobacco, its effects on health. He's at the other end of the chain at this point. I don't know what you're getting at and why it was necessary to go through that routine of how long it takes for the operation.

What does that got to do with the case?

MR. ROSENBLATT: From my standpoint, I'm going to get very -- and I can do it almost immediately. I don't have a problem with that. I'm going to discuss causation and addiction with him. And obviously he's different from someone who's been involved in the literature or who's been involved in the field.

So, that's a perspective. It's all by way of background.

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THE COURT: He's going to treat, say, from several years ago, and he wouldn't be familiar with the person's lifestyle up to that point. I mean, he only gets secondhand on the history. So if you're going to get into that, that's okay, what he knows about the history and what his clinical observations are.

It's very interesting if we had a heart transplant type case. I just want to speed it up.

MR. ROSENBLATT: That's fine.

(The sidebar conference was concluded, and the following proceedings were held in open court:)

BY MR. ROSENBLATT:

Q. Dr. Staples, in terms of the histories that either you personally get or someone on your team gets and is made part of the patient's hospital chart, is smoking history important?

A. It's a very critical issue in both of these transplants.

Q. And why is that?

A. It somewhat relates -- well, it relates to their degree of medical compliance. It relates to their predicted ability to comply after surgery with medical advice. Because if they discontinue, say, for instance, taking Cyclosporin or their steroids on their own or make a unilateral decision to do that, the organ

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will reject and they will die. And that's not the goal of our surgery or our treatment for these patients.

So, we select recipients who are good soldiers; they do what we tell them to do. And part of that is related to cigarette smoking cessation. If they have been advised, treated, counseled and still continue to smoke, we feel that this is a failure of medical compliance, and we'll seriously consider their not receiving an organ.

And on the opposite side of the transplant, after receiving the organ, if they return to smoking, then smoking will accelerate the atherosclerosis that will develop in the donor heart, or it will create the asthmatic COPD condition in the donor lung. And that complicates our treatment of their postoperative course.

So we feel smoking is a pivotal issue in transplantation.

Q. Have you had patients who you were preparing to get ready to receive either a heart or a lung who were smokers, and in spite of your very strong recommendations, could not stop smoking?

MR. ROSS: Objection, Your Honor.

THE COURT: I'll overrule as far as the question is concerned, his personal experience.

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MR. MOSS: Judge, can we go sidebar on that question?

THE COURT: If you'd like.

(The following proceedings were had at sidebar:)

MR. MOSS: What we object to is his question was "and could not stop smoking." He doesn't know if they could not. That's what we object to.

The proper question is "did not." He can't step into their minds.

THE COURT: Sure he can, if they expressed it to him.

MR. MOSS: Number one, it's hearsay, and it hasn't been asked. The way the question has been asked, we object to the form, and a proper question would be, we submit, "have not stopped."

THE COURT: We're talking about a medical condition from a patient to a doctor.

MR. MOSS: But that hasn't been asked, sir. And by allowing that question, we assume the jury will imply that he could not rather than he did not.

THE COURT: I don't know what his answer is. Overruled.

(The sidebar conference was concluded, and the following proceedings were held in open court:)

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BY MR. ROSENBLATT:

Q. Dr. Staples, in your practice, have you had patients you were getting ready to receive a heart or to receive a lung who could not stop smoking?

A. No. They universally have to quit.

Now, that's not hard in the lung case, because these patients are so short of breath that they would have the sensation of suffocating if they smoked a cigarette. They physically can't smoke a cigarette they're so debilitated. It's impossible for them to.

Not only is it impossible, but it's dangerous, because every single lung transplant recipient is on oxygen. And the combination of oxygen and fire don't mix; it's explosive. So it's not only impossible, but it's harmful, or dangerous.

In terms of the heart transplants, no, they don't -- those two issues don't exist in heart transplantation. However, half of the heart transplants that we perform and the United States performs as a group are due to coronary artery disease. Coronary artery disease is what we talked about yesterday in causing heart attacks. The heart attacks lead to the heart failure. Heart failure then leads to sometimes heart transplantation.

In those patients who have heart failure due

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to heart attacks due to cigarette smoking, they have universally quit. We do not transplant hearts in current smokers.

Q. So it's a precondition, in order for you to put in the heart or the lung, the smokers must have quit smoking?

A. They must have quit.

Q. For how long before the actual surgery is performed?

A. In the case of heart transplants, we require six months. In the case of lung transplants, we require two years.

Q. Why that long?

A. Those are just the guidelines that we have set up that our pulmonologists have decided to establish. And this is a universal rule.

Q. In terms of those patients who have difficulty quitting before, quitting smoking before the actual surgery, do you get involved in treating the smoking, the continued smoking so that they can, in fact, stop?

A. Not in the case of heart or lung transplants. In other surgeries that I do, for instance, coronary bypass surgery or lung cancer surgery, yes, I do get involved in their treatments. But not in terms of the

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heart and lung transplant recipients.

Q. So then tell us, Doctor, in terms of lung cancer treatment or coronary artery bypass surgery, when you've got a patient who you've told to quit smoking and they continue to smoke, what types of treatment have you personally recommended and instituted for these smokers?

A. Well, at first is a sit down talk. I mean, you've got to meet them face to face, eye to eye and give them the real scoop.

The first time that we talk to the patients, I don't bring them the lung specimens that you have seen or the heart specimens. It may or may not be necessary. But certainly a serious talk with a patient about the relation between cigarette smoking and postoperative complications is the focus of the discussion.

Even though I may see a patient for coronary bypass surgery and realize that I'm just going to be touching his heart, the complications that and the deaths that I experience after those surgeries are related to their lungs and pneumonia and the infections of the lungs that cause a great deal of -- well, cause prolonged hospitalizations and cause death after seemingly uncomplicated heart surgery, the lungs then

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cause the problem.

And this is the pivotal issue in smoking cessation prior to these surgeries is to reduce the lung complications of the operations of the two, open heart surgery in general and lung surgery in general, not heart transplantation and lung transplantation.

Q. And if the talk doesn't work and if the smoker continues to smoke, what's your next step in terms of treatment?

A. Again, it's a clinic visit, and we re-interview the patient and the family. Not only myself, my nurse practitioners, my fellows, residents interview the patients relating to that to confirm that he has or hasn't quit.

If, in the case that he says, no, I haven't quit, I've cut back, but haven't quit, then they will be referred to a local stopping smoking clinic.

Again, I'll bring them back, how is it going? If they still haven't quit, then I'll try to get a sense of what it is that's preventing them from quitting -- is it anxiety? Is it nervousness? Is it sleeplessness? Is it their environment? Does the wife smoke? Do they work in a smokey place -- and try to alter that situation. And if they can't quit at that point, the ultimate preparation is to hospitalize them.

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Q. And have you actually done that with some smokers?

A. Oh, yes. Bring them into the hospital, admit them, put them on IV antibiotics where they're tied to an IV pole. The IV antibiotics are to treat the bronchitis that is chronically there. Give them anxiolytics, but not to the point of sedation. And of course, see them at least daily myself and at least four or five times a day by my staff. And we'll do that up to two weeks prior to surgery, depending on how bad their lungs were.

Q. Have you had any patients, whether it required hospitalization, whatever method you had to utilize to get them to stop smoking and then you went ahead with the surgery, whether it was coronary artery bypass surgery or lung cancer surgery, where, following the surgery, the patient took up smoking again?

A. Absolutely.

Q. How often does that happen?

A. Frequently. It's highly disappointing to me, but it's a frequent occurrence. And even after heart and lung transplantation, they will return to smoking. Although they have quit for years prior to those surgeries, they will then return to cigarette smoking to generate the same disease that they -- potentially

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the same disease that they had the surgery for.

Q. And presumably you've told them that the reason for their disease, the reason for the surgery is smoking, is their history of smoking?

A. I hammer that into them. I'm relentless about that.

Q. Nonetheless, a certain percentage, even after the surgery, go back to smoking?

A. A certain percentage do.

Q. Dr. Staples, what diseases do you treat that, in your medical opinion, based upon reasonable medical certainty, are caused by cigarette smoking?

A. In my area of specialty, the diseases that you saw yesterday are all caused by cigarette smoking; that is, emphysema, lung cancer, coronary artery disease and atherosclerosis in general.

MR. ROSENBLATT: Thank you, Dr. Staples.

THE COURT: Cross?

MR. ROSS: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. ROSS:

Q. Morning, Dr. Staples. My name is David Ross.

A. Morning, Mr. Ross.

Q. I'm going to ask you some questions on behalf of the defendants in this case.

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Let me start out talking about your curriculum vitae that you talked about at great length yesterday.

Dr. Staples, I'm correct, aren't I, that none of the items on your curriculum vitae, any of the articles that you've written, et cetera, deal directly with the cause of lung cancer?

A. No, they do not.

Q. None of them deal directly with the cause of coronary artery disease?

A. They do not.

Q. Nor emphysema?

A. Nor emphysema.

Q. Dr. Staples, you, in fact, have never done any research on the causes of the cancer yourself, have you?

A. That's, in fact, true.

Q. And other than the presentations that you told us about yesterday to your daughter's class and then other classes, the school children presentations that you talked about, you yourself have never actually made any scientific presentations on the causes of lung cancer, correct?

A. That's correct.

Q. Nor have you ever made any scientific

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presentations to groups of doctors or scientists on the causes of coronary artery disease?

A. Correct.

Q. You are not, as we sit here today, you're not a reviewer on any peer-reviewed medical journals, correct?

A. Not today, correct. Correct.

Q. As I think you've told us, Dr. Staples, you're a surgeon, and your goal is to operate and treat the diseases that we're talking about, correct?

A. Exactly.

Q. Now --

A. And to try to prevent those diseases.

Q. The person who would examine samples of tissue such as you brought to this courtroom yesterday and showed the jury to determine what kind of cells are in those tissues, what kind of diseases are found within those tissues, that would be a pathologist, wouldn't it, Dr. Staples?

A. In terms of exactly what you said in examining cells and the like, pathologists do that on a routine basis. I do that on a routine basis also in the patients that have lung cancer and also the patients that I transplant, do lung transplantation on, we routinely review the pathology. That is, the actual

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microscopic slides of those patients.

So, although I don't sign the bottom of the page that said this patient had emphysema, I'm certainly very familiar with the cells that you're talking about in cancer and emphysema.

Q. And there are different types of lung cancer cells, are there not?

A. There are, yes.

Q. So when we say, when somebody uses the word lung cancer, in fact, there are a number of different types of lung cancer that we might be talking about, correct?

A. Yeah. But I don't want to confuse the issue. Lung cancer is caused by cigarette smoking regardless of whether it's squamous cell carcinoma, bronchoalveolar carcinoma, adenocarcinoma, you know, anaplastic carcinomas. There's a whole, like you say, different types. But as a group of cancers, 90 percent of all cancers are caused --

Q. Dr. Staples --

A. -- by cigarette smoking.

Q. Let me just ask that you answer the question that I'm asking.

A. I did.

Q. There are different types of cancer cells,

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are there not, Dr. Staples?

A. There are.

Q. Let me see if I understood what you just said, because we'll come back to that. Is it your testimony here today that every single different type of lung cancer cell is associated with smoking?

A. Lung cancer in general as a diagnosis is caused by cigarette smoking. Individuals with that, with different specific cell types, there are varying statistical relationships between smoking and various cell types. By far the largest two are squamous cell carcinomas or large cell carcinomas and small cell carcinomas.

Q. Dr. Staples --

THE COURT: I'm not sure he's finished.

BY MR. ROSS:

Q. Go ahead.

A. Those two groups comprise 90 percent of all lung cancers. There are other types like bronchoalveolar that are less frequent, and we do find those in smokers in greater frequency than in nonsmokers, whether that's the actual -- smoking is the actual cause of bronchoalveolar carcinoma specifically. It may be in some patients. It may be not in others.

Q. In fact, Dr. Staples, you'll agree with me,

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won't you, that there are some tumors and malignant tumors in the lungs that are not associated with smoking at all, correct?

A. Statistically speaking, correct.

Q. For example, malignant carcinoid tumors, which are a form of lung cancer, are not associated with smoking at all, are they, Dr. Staples?

A. Correct.

Q. Some, such as the one you just mentioned, bronchoalveolar carcinoma --

A. Bronchoalveolar.

Q. I'm sure you pronounce it better than I can -- those are found much more in nonsmokers than smokers, correct?

A. Yes.

Q. In fact, all the different type of lung cancer cells can occur in nonsmokers as well as smokers, correct?

A. They can occur in nonsmokers.

Q. And it's true, is it not, that sarcomas of the lung, which is also a form of lung cancer, those aren't associated with lung cancer at all, are they, Dr. Staples?

A. That's correct.

Q. In fact, isn't it true that each individual

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has a different threshold for the development of lung cancer?

A. I suppose you can say that, from a lay standpoint, even from a medical standpoint. I don't know exactly what a threshold for cancer, your threshold or my threshold for cancer is. No one knows that.

Q. No one knows that, do they?

A. No, they don't.

Q. Now, it's also true that many lung cancers, many cancerous tumors that appear in the lung, in fact, are not primary lung cancers, but they're, in fact, tumors that have metastasized or traveled from somewhere else in the patient's body and then a tumor has appeared in the lung?

A. If you're talking about cancers that are in the lung, that's true. However, that's not what we're talking about when we say lung cancer. Metastatic cancer to the lung is colon cancer that's metastasized to the lung or thyroid cancer that's metastasized to the lung. That is not considered lung cancer.

So, yeah, it's found there, but it's not lung cancer.

Q. The sample of lung cancer that you brought to this courtroom yesterday and showed to the jury, you

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don't know the clinical history of that particular patient, do you?

A. No, I don't.

Q. And if I understood what your testimony was yesterday, you don't know the particular type of cancer that was in that particular sample that you brought here yesterday?

A. No, I don't.

Q. So you don't actually know whether that sample that you brought and showed the jury yesterday was an example of a primary lung cancer or a cancer that had metastasized from somewhere else in the body?

A. Wrong. I do know that it's a primary lung cancer.

Q. How do you know that?

A. Because that specimen is a surgical specimen. Surgery to remove cancers are done for primary lung cancer. They're not done for metastatic cancers.

Q. Now, you don't know, do you, Dr. Staples, the percentage of smokers who actually get lung cancer?

A. No, I don't know that exact number.

Q. But you will agree with me that it is only a minority of smokers who ever develop lung cancer?

A. Thank God that's true.

Q. And we talked a moment ago about everyone

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having a different threshold, and you will agree with me that among individuals, among other things, it may depend on how many cigarettes they've smoked, how often they've smoked, length of exposure; that's correct?

A. In general, the longer you smoke, the more frequently we see lung cancers develop.

Q. You'll agree with me that there are unknown causes of lung cancer that science hasn't even discovered yet, correct?

A. That's true.

Q. And isn't it correct, Dr. Staples, that neither you nor, in fact, anybody in the medical community knows just exactly how cigarettes are related to the development of lung cancer?

A. That's exactly right. I just know that cigarette smoking causes lung cancer. How that happens is still, you know, waiting for a recipient of the Nobel Prize.

Q. What we're talking about here is what science would refer to as the mechanism, correct?

A. Yes.

Q. And the mechanism is what would tell us in a laboratory type setting what, if anything, about exposure to something, whether it be cigarette smoke or radon or anything else, what, if anything, about

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exposure to that material might cause changes in human cells that ultimately lead to cancer. That's what we refer to when we talk about the mechanism of a disease?

A. That's a good way to put it.

Q. And science doesn't know the mechanism to lung cancer, does it?

A. No.

Q. And I think you said just a moment ago, if anybody did know that, they'd probably get the Nobel Prize for medicine, wouldn't they?

A. They sure would. That still doesn't detract from the fact that cigarette smoke causes lung cancer.

Q. Dr. Staples, you'll agree with me that we do know some of the other risk factors for the development of lung cancer, correct?

A. Oh, absolutely.

Q. One of those is radon?

A. Yes.

Q. That's something that people can get exposed to in their homes?

A. Correct.

Q. And in fact, unfortunately, radon is fairly prevalent in north Florida, north central Florida, the area where you live, for example?

A. Exactly.

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Q. It's very difficult to test for radon exposure in the area where you live and work, isn't it?

A. No. You can buy the kits at the local hardware store.

Q. It's difficult to test the person --

A. Yes.

Q. You can find it in the area, but it's difficult to test a person to know how much exposure to radon they've gotten?

A. Yes.

Q. You'll agree with me that lung cancer is what we call a multi-factorial disease; that is, there are a number of risk factors associated with it?

A. There are a number of causes, yes.

Q. Assuming that a patient of yours has had exposure to a number of the different risk factors for lung cancer, it's, in fact, difficult, if not impossible, to decide in any particular patient what the role of any one of those different risk factors might have been in the development of that person's lung cancer?

A. Looking at it that way, that's true. However, if you look at it from the perspective that if a patient who smoked and develops lung cancer had never smoked, would that patient be sitting in your office on

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July 12th. And that would be -- the answer to that question would be undoubtedly no.

The combination of radon and cigarette smoking or asbestos and cigarette smoking are considered to be synergistic. And so, in terms of causes that we know of, the actual occurrence of the disease would undoubtedly either never happen or be delayed if they had never smoked.

Q. Dr. Staples, assume that you have a patient with multiple risk factors, take the three that you mentioned, cigarette smoking, radon, asbestos, been exposed to all three; you can't rule out the role of any one of those risk factors in the development of a disease like lung cancer, can you?

A. No, you really can't.

Q. Now, the specimen of lung cancer you brought to this courtroom yesterday, you can't tell what type of cancer it is just by looking at it, can you?

A. I cannot.

Q. In fact, nobody could?

A. Nobody could.

Q. So, just by looking at that, we don't know if it was a sarcoma or carcinoid tumor or what it was just from visually looking at it?

A. Not exactly. Different tumors have different

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looks. Typical adenocarcinoma and squamous cell carcinoma that cavitate like that are very -- it's very characteristic, sarcomas are solid, they're like baseballs, they're hard, they don't cavitate. They just grow as a solid mass of cancer and don't cavitate.

Carcinoid tumors that are malignant typically infiltrate where they send out little tentacles down the airways. So, no, I would disagree with your characterization of that as potentially being a sarcoma or carcinoid tumor. But to say with absolute certainty that it's not would require microscopic examination.

Q. And you haven't done that on that particular sample that you brought?

A. No, I have not.

Q. Let me turn to one of the other diseases that you mentioned to Mr. Rosenblatt in the very last question that he asked you. I believe you testified that, in your opinion, you said, smoking causes emphysema?

A. Yes.

Q. As I understand your opinion, you think that all emphysema is caused by smoking?

A. All emphysema that is clinically significant in adult age groups, yes.

Q. One hundred percent of what we would call

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symptomatic emphysema is caused by smoking; that's your opinion?

A. That's my testimony in deposition before, yes, sir.

Q. And I'm not trying to refute that. That's still your opinion as you sit here today?

A. Yes, sir.

Q. Do you know who Dr. Julius Richmond is?

A. Surgeon General.

Q. Former Surgeon General of the United States?

A. Former Surgeon General.

Q. You're familiar with him?

A. I know the name.

Q. I noticed yesterday that you were in the courtroom while I think it was Dr. Benowitz was testifying.

A. Dr. Benowitz.

Q. But you didn't happen to be here a few days ago when Dr. Richmond was testifying, did you?

A. I was not.

Q. Have you learned from any source that Dr. Richmond testified that not 100 percent of emphysema was caused by smoking?

A. No.

Q. If I were to then -- if you would just assume

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with me hypothetically that Dr. Richmond, who testified in this courtroom just a few days ago, testified that it is not correct that 100 percent of emphysema is caused by smoking, you would just simply disagree with the doctor, correct?

MR. ROSENBLATT: I'm going to object, Your Honor, comparing one witness's testimony with another.

THE COURT: I'll sustain it on that basis, but I think we ought to talk about it.

(The following proceedings were had at sidebar:)

THE COURT: The problem arises because we have two kinds of things, I think, that overlap. And one is comparing testimony or opinions.

MR. ROSS: I'll ask it hypothetically.

THE COURT: That's the problem. You've already done the damage in that you mentioned Dr. Richmond in his testimony. The law does provide that a witness, expert, can form the basis of his opinion in matters that he's learned even at trial.

And if it's a factual matter that comes out that a fact was, or there was testimony that -- but from whom and under what circumstances, that's what's the problem. But that's already there. The damage is done.

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MR. ROSS: Well, he's also recognized Dr. Richmond. And I could, for example, take an article and say, do you recognize this article as authoritative?

THE COURT: He may recognize him by name only, but may not recognize his expertise in the field. I don't know. But the point being that if you had learned that there is this kind of testimony.

MR. ROSS: I'll ask it that way.

THE COURT: On the other hand, as I understand these rules, they're trying to do away with hypotheticals, which I think is a very good idea.

MR. ROSS: But they haven't.

THE COURT: Essentially they have. So, along those lines, I think you have to narrow it down. How we can cure this fact already, I don't know.

MR. ROSENBLATT: Probably go on to something else and come back.

MR. ROSS: I'll ask hypothetically, anybody, another expert testified that he --

THE COURT: Another expert, but that's where the problem comes in. If you say there has been testimony in this court --

MR. HEIM: The way to ask it would be if there were testimony to the effect that, would you

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agree.

MR. ROSS: That's the way I'll ask it.

THE COURT: That's the way you should have done it.

(The sidebar conference was concluded, and the following proceedings were held in open court:)

BY MR. ROSS:

Q. Let me just ask you this question, hypothetically. If you were to learn that there was testimony in this case from other physicians that not all emphysema is caused by smoking, you would disagree with that?

A. I'd have to talk to the patient -- or to the other physician and come to an understanding about exactly what we were disagreeing on.

Q. Now, we talked a few moments ago -- let me ask you something. Disagreements among physicians about cause are not uncommon in the medical world, are they, Dr. Staples?

A. Generally speaking, true.

Q. And from a medical standpoint, generally speaking, you wouldn't be critical of someone else who had a different opinion than you did?

A. Not generally speaking, true.

Q. With emphysema, just like with lung cancer

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that we talked about a few moments ago, you yourself don't actually -- although you believe that smoking causes cancer, that's your opinion, you don't know how smoking causes emphysema, do you?

A. No, I don't.

Q. Again, you don't know the mechanism for that relationship?

A. No, I don't.

Q. And in fact, you don't believe that anybody does, as far as you know, in medical science today?

A. Not exactly. I mean, there are things in cigarette smoke, oxidants and many other toxins, which have the potential for damaging lungs. But how that actually creates the bubble popping process of emphysema, I don't know.

Q. In fact, for emphysema in general, the actual reason why the lung is destroyed in emphysema is still a matter of actual scientific research today?

A. That's true.

Q. You also talked about -- that last answer you talked about atherosclerosis, correct? And you said, I believe, that, in your opinion, atherosclerosis is caused by cigarette smoke?

A. That's correct.

Q. Now, atherosclerosis, the process that you

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drew us a picture of yesterday with the plaque building up in the arteries, that's a life-long process that all of us undergo to some degree; isn't that correct?

A. That's true.

Q. Regardless of whether we've ever touched a cigarette in our life, we're all going to get some level of atherosclerosis?

A. That's true.

Q. And it, in fact, begins very early in our lives; when we're teenagers it happens?

A. Yes, it does.

Q. And there are lots and lots of known risk factors for the development of atherosclerosis, aren't there?

A. Yes.

Q. And some of the ones that we know about are high blood pressure; do you agree that's a risk factor?

A. Yes.

Q. Family history; that's a risk factor?

A. Yes.

Q. High cholesterol is one we all hear about all the time?

A. Yes.

Q. High triglycerides?

A. Correct.

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Q. And we do know that high cholesterol and high triglycerides, that is substantially affected by the diet that we all eat?

A. Especially triglycerides.

Q. If we're all out there eating a lot of high cholesterol foods and very fatty foods, that's going to lead to high cholesterol or high triglycerides, correct?

A. That's correct.

Q. And in your judgment, that will accelerate this atherosclerosis process that we're all undergoing?

A. That's correct.

Q. Diabetes, that's another disease?

A. Yes, it is.

Q. In fact, unfortunately for you and I, just being a male is more of a development -- more of a risk of developing atherosclerosis than being a female?

A. Yes.

Q. Obesity, that's another risk factor for atherosclerosis?

A. That's true.

Q. Again, you'd agree that coronary heart disease, coronary, I want to use the term you used, coronary artery disease I think is the name you gave it, that's a multifactorial disease as well, correct?

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A. Yes, sir.

Q. And you are not, I take it, telling this jury that, in your opinion, all heart attacks are caused by smoking?

A. I'm certainly not telling them that.

Q. Sedentary lifestyle is a risk factor for coronary artery disease, isn't it?

A. Yes.

Q. And I believe physical inactivity has been found to be a risk factor for coronary artery disease, hasn't it?

A. Restating your previous statement.

Q. And you agree with that, correct?

A. Yes.

Q. Now, again, as we talked about with the other diseases, nobody knows the mechanism by which these various risk factors that we've talked about caused the plaque to develop in our arteries, correct?

A. That's true.

Q. So we don't know what it is about high cholesterol that might result in the plaque building up faster?

A. Right.

Q. Or high triglycerides or any of these other factors we've talked about?

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A. Yes, sir.

Q. And the same is true that, even though, in your opinion, cigarette smoking is one of these, we don't know what it is about cigarette smoking, if anything, that would cause this plaque to build up faster in our arteries?

A. Yes.

Q. And again, like with lung cancer, some individuals get heart disease that we don't -- can't find any of these risk factors for that particular individual. Some people just get heart disease without any identifiable risk factor, correct?

A. Are you talking about coronary artery disease?

Q. Yes, coronary artery disease.

A. To a very, very small extent, that's true. It's a rare person who we can't blame it on something.

Q. And you would agree with me that the proportion of people who get coronary artery disease who have smoking as one of these risk factors but no other risk factor is actually a minority of people who get coronary artery disease, correct?

A. Your question is having no other risk factor except cigarette smoking would be a rare patient, is that your question?

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Q. That would be -- out of all the people who get coronary artery disease, that would be the minority that would only have cigarette smoking as a risk factor and not other risk factors as well?

A. Correct.

Q. And again, as we talked about with lung cancer, if you're presented with a patient that has multiple risk factors out of this list -- let me side track for a second. We haven't covered the whole list.

There are probably 200 risk factors reported in medical literature for coronary artery disease, aren't there?

A. I don't know the number.

Q. Does that sound --

A. That's probably more than we originally went over, but I don't know if it's 200. Certainly more than the 10 or so we talked about.

Q. If you had had a patient who had a number of these risk factors, doesn't matter what they are, pick one from Column A and one from Column B and one from Column C, it's impossible to determine in such a patient, given the state of medical science today, which of those risk factors were the cause of that person's heart disease?

A. True.

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Q. So, again, for each of these diseases that you've talked about, science does not know the mechanism of the cause of any of these diseases?

A. We're not at that stage of science yet.

Q. And in addition to laboratory work, one of the things that science might do to investigate and get us to that level of knowing the mechanism is also use what's called animal models, correct, where you expose animals to the same sorts of things that are these risk factors and see what happens to the animal?

A. If it confirms the observations seen in humans, then it's beneficial. But many times what's observed in animals has no relationship to what happens in humans.

Q. But you will agree with me that that is one of the procedures that science uses, it's an investigatory tool that science uses?

A. It's simply a tool.

Q. You will agree with me that today there is no animal model that has been developed which has reproduced cardiovascular disease in animals exposed to whole cigarette smoke, correct?

A. That I know of, correct.

Q. You talked a little bit about your experience, Dr. Staples, with people who smoke for whom

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you had to perform surgery and your attempts to get them to stop smoking. And you talked about that. But in fact, isn't it true that, in your experience, your practice, your group of patients who smoke and required surgical treatment for some disease, you found that only approximately between 10 and 30 percent couldn't quit smoking?

A. That's what I've stated before, yes.

Q. So, in fact, in your own practice, 70 to 90 percent of your patients could quit smoking?

A. Under the right circumstances, yes.

Q. I'm saying, in your practice, that's been your experience?

A. Yes.

Q. And you talked about your experience with some people who wanted to smoke even after their operation. But, again, the fact is, in your practice, most of the people that you've treated have not continued to smoke after surgery, correct?

A. Thank goodness, yes.

MR. ROSS: I have no further questions, Dr. Staples. Thank you.

THE COURT: Anybody else from that side?

REDIRECT EXAMINATION

BY MR. ROSENBLATT:

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Q. Obviously, I'm only asking for a rough estimate, because I'm sure you don't have it down to a precise number. Since you've been in practice, after you completed all your training, how many patients do you figure that you've either done surgery on, treated, gotten ready for surgery?

Are we talking, hundreds, thousands?

A. Thousands.

Q. Is it accurate to say that, as a clinician and surgeon, you are very interested in what caused them to be sitting in front of you and to become a candidate for the kind of surgery you perform?

A. Yes.

Q. Now, Mr. Ross asked you a bunch of questions about the types of lung cancer, different types. And without question, there are different types of lung cancer, correct?

A. Correct.

Q. Now, when you say that 90 percent of lung cancer is caused by cigarette smoking, are you applying that to all the different types of lung cancer?

MR. ROSS: Objection, Your Honor. This goes beyond the scope of redirect.

I'll approach if you want me to say anything further.

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THE COURT: I don't think so.

Overruled.

BY MR. ROSENBLATT:

Q. When you gave that number that 90 percent of lung cancer is caused by cigarette smoking, were you encompassing all the different types of lung cancer?

A. Yes.

Q. And counsel asked you about does everybody have a different threshold for developing lung cancer. So what is a safe threshold for smoking from a medical scientific standpoint where you can say, hey, it's okay, smoke three, four cigarettes a day?

A. As far as I'm concerned, there is no safe threshold. The more you smoke, the more likely you are to get lung cancer. As a matter of fact, you don't even have to smoke to get lung cancer. You can be exposed to others --

MR. ROSS: Objection, Your Honor. Let me approach.

THE COURT: Well, I'm not so sure I agree with you on that. I think we went into causation on cross.

Overruled.

BY MR. ROSENBLATT:

Q. You can complete your answer, Doctor.

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A. If you regularly inhale other people's cigarette smoke and not be a smoker yourself, that is a nonsmoker, but exposed to cigarette smoke, you can get lung cancer from that exposure.

The nonsmoker, nonexposed, that is, someone who doesn't smoke, who doesn't get exposed to somebody else's cigarettes rarely, rarely contract cancer. Out of the hundreds, 500 patients that I've treated or more with lung cancer, very few, just less than 10, have ever claimed to be nonexposed nonsmokers.

Q. And out of those 500, Doctor, in any of them, did you ever make a determination that a patient you were treating for lung cancer, that the cause of that individual's lung cancer was their exposure to radon?

A. I've tried to do that in a number of patients, as Mr. Ross indicated, because of our location in north Florida and high radon contents in that area.

That's not a standard part of medical testing to put radon detectors in several rooms of patients' houses and get results back. But I have attempted to do that on numbers of occasions.

Q. In what percentage of your patients with lung cancer have you determined that smoking, active smoking was the cause of their lung cancer?

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A. By far almost all of them.

Q. Counsel asked you, he said, well, Doctor, disagreements about cause are not uncommon amongst doctors. And my question to you, sir, is, that if you met a doctor who said in 1998, I don't believe that cigarette smoking causes lung cancer, I don't think it's been scientifically proven, I have some doubt about that; what would you think of that opinion?

MR. ROSS: Objection, Your Honor.

THE COURT: Overruled.

THE WITNESS: Well, as I went over with Mr. Ross, the science of causation is still out there. The fact that smoking causes these diseases is well established. The mechanism or the science of that is not. And certainly I'd want to talk with this individual about why he felt that way. But I would respectfully have to disagree.

BY MR. ROSENBLATT:

Q. Now, for example, although we don't know, for example, why high cholesterol causes the plaque build-up in the coronary arteries, is it a universal medical recommendation for patients to lower their cholesterol?

A. Below a certain level or if their level is above a certain level, yes, it is a universal

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recommendation to get it down to that level.

Q. And is there, without knowing the precise mechanism about how cigarette smoking causes a good cell to go bad, or the precise mechanism of how lung cancer begins, is there, in your experience, a universal medical recommendation on the issue of smoking; and, if so, what is it?

A. Absolutely, that cigarette smoking causes the diseases that we've been talking about here, that is, lung cancer, emphysema and atherosclerosis, whether it's of the abdominal aorta or at the coronary arteries, there's no controversy about that.

Q. And Dr. Staples, when the Surgeon General of the United States concluded in 1964 that cigarette smoking causes lung cancer in men, they didn't know the precise mechanism 34 years ago, did they?

MR. ROSS: Objection, Your Honor. Beyond the scope. Also leading.

THE COURT: Well, it goes to mechanism. Overruled.

BY MR. ROSENBLATT:

Q. Did they know the precise mechanism back in 1964?

A. No, they didn't.

Q. Do they know the precise mechanism in 1998?

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A. No, they don't.

Q. But during those 34 years, in the real world, doctors have been treating patients and making recommendations; is that correct?

A. Absolutely.

Q. And in terms of your own patients, Doctor, where you're doing a heart transplant or a lung transplant, as I've understood your testimony, unless the patient stops smoking, they're not going to get the organ?

A. That's true.

MR. ROSENBLATT: Thank you very much.

THE COURT: All right, Doctor. Thank you very much. Appreciate you coming. Good luck tomorrow and the rest of the week.

THE WITNESS: I think it will go well.

THE COURT: Weather permitting and everything else.

All right. Let's take a short recess.

(The jurors exited the courtroom.)

THE COURT: All right. What is the next order of business?

MR. ROSENBLATT: Dr. Joe Davis, and I assume he's at my office. I'm going to call my office.

THE COURT: Is he going to be what, the rest

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of the day?

MR. ROSENBLATT: Well, he's the only other witness I have.

THE COURT: For today?

MR. ROSENBLATT: Yes, for today.

THE COURT: All right.

(Recess)

THE COURT: Everybody ready?

Bring the jury out, please.

(The jurors entered the courtroom.)

THE COURT: Okay. Everybody ready?

Present your next witness, please.

MR. ROSENBLATT: Dr. Joseph Davis.

Thereupon:

JOSEPH DAVIS, M.D.

having been called as a witness, was duly sworn, examined, and testified as follows:

DIRECT EXAMINATION

BY MR. ROSENBLATT:

Q. Good morning, Dr. Davis.

A. Good morning.

Q. For the record, please tell the jury your full name and your professional address.

A. Joseph H. Davis. My professional address is the Medical Examiner Department, Number 1, Bob Hope

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Road, which is also 1851 Northwest 10th Avenue, Miami, Florida.

Q. You are a medical doctor?

A. Yes.

Q. And you are a pathologist specifically?

A. Yes.

Q. And what does it mean to practice the specialty of pathology?

A. Well, medicine is divided up into a number of different specialties. And that specialty that deals with the laboratory side of medicine, not the patient care side, but the laboratory side where specimens are examined from surgical cases, where autopsies are done, where the chemical tests and blood tests are done from the various patients, that is the practice of pathology.

It does involve some patient interaction in the hospital setting because some of the hospital pathologists involve the acquisition of specimens from patients, but for the most part it's laboratory oriented.

Q. What I intend to do, Doctor, is kind of take you through, in chronological order, your curriculum vitae, your medical education and training.

Before you went to medical school, you

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attended Princeton University undergraduate?

A. Yes.

Q. What did you major in?

A. Well, that was premed.

Q. And then where did you go to medical school and what year did you graduate?

A. That was the Long Island College of Medicine, which is now the Downstate. Back then it was a private medical school. Now it's a state medical school, and they changed the name. But that is in Brooklyn, New York. And I graduated in 1949.

Q. And in terms of any training after you received your M.D. degree, internship or residency, tell us about that.

A. Well, rather than take a rotating internship, which means studying various branches of medicine, various specialties, I took what was called the straight surgical internship, which meant that I spent a year in the surgical service at the University of California in San Francisco.

That was a major medical care center. So, the surgical procedures that were done there were the major procedures, thoracic surgery, major abdominal surgery, neurosurgery and so forth. And I spent a year doing that.

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I finished there that first year and decided to spend a year in the pathology department in order to broaden my perspective of different types of diseases and their various manifestations. And when I joined the pathology department, I was also in the reserves for the U.S. Public Health Service.

Previously I had been in the U.S. Army. And then after the World War II, later I joined the Public Health Service, was in its reserve program. But I started at the University of California in the department of pathology, spent half a year, and then the Public Health Service called me up for active duty.

So, then I went back into the field of patient care again. I spent about a year and a half, I believe, at the Indian hospital, Bureau of Indian Affairs in Tacoma, Washington, that was a referral hospital where Indians who had special medical and surgical problems were shipped in from the northwestern part of the continent.

Also during that period of time I was assigned to three, for short periods of time, three different reservations, one in Montana and two in Arizona, at which time I was responsible for the patient care in these particular small hospitals. So, my duty with the Indian service was in a large hospital

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and then three other small hospitals.

I then spent two more years in pathology at U.S. Public Health Service hospital in Seattle, Washington and an additional year at the U.S. Public Health Service Hospital in New Orleans, Louisiana. And about that time, my tour of duty with the Public Health Service was finished.

So, I joined the faculty at the Louisiana State School of Medicine and became an instructor in the department of pathology. So that was more or less my semi-academic training in that particular phase of my career.

Q. So in terms of your stint with the United States Public Health Service, and you took care of the Indians and you went to their hospitals and the Indian reservations as part of your duties with the United States Public Health Service?

A. Yes. What happened was the United States Public Health Service would assign physicians to the U.S. Department of Interior, which administered the hospitals. And we furnished the medical staff care for the patients.

Q. Okay. And so how long overall was your work with the United States Public Health Service?

A. Well, it would be about one and a half years

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in clinical practice working with patients in the Indian service. Then an additional three years, so it's about four and a half years.

Q. Now, you were in two different roles in New Orleans. For a period of time you were with the United States Public Health Service. Then you joined the faculty of Louisiana State University?

A. Yes.

Q. How long did you remain on the faculty of the Louisiana State University School of Medicine?

A. My best recollection of that -- we're getting back to quite a while ago. My best recollection of that is about a year and a half. Because I know that in 1956, in March of 1956 I left New Orleans and came to Dade County to join the newly created medical examiner department of Dade County.

But while in New Orleans, I was on the faculty teaching, assisting the laboratory work with the students and also was performing autopsies for the coroner, the younger faculty members of both Tulane Medical School, University School and Louisiana State School of Medicine would rotate through the coroner's office, and that's really where I got started in forensic pathology.

Q. What were the circumstances under which you

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left New Orleans and came to Miami?

A. Well, Dade County never had a medical examiner department. And a law was passed in 1955 creating such an entity. Then a search was made for a director. And that first director was Dr. Stanley Durlacher, who was also on the faculty at Louisiana State University and had developed the laboratory facilities for the coroner's office in New Orleans. And he was chosen to come here, and he brought me with him as his assistant. Well, we opened our office here in 1956, March 15.

Q. And I see from your curriculum vitae and, of course, obviously, this is how you spent by far the major part of your career, you were, in fact, the chief medical examiner and director of the medical examiner department in Dade County for a long time, 1958 through 1996?

A. Yes. What happened was Dr. Durlacher, unfortunately, died of a stroke. He was visiting in Chicago at a meeting and collapsed at the meeting and died. That was in February 1957. And I was appointed acting director. And then the following year in 1958, the county commission appointed me as the -- or county manager appointed me as the director.

Q. Now, I'm not necessarily pinpointing this to

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when you began in 1958, but overall, as the chief medical examiner for a county as large and diverse as Dade County, what was your mandate, what was your role?

A. Well, there was actually a statutory role. There was a state law that set the duty of the medical examiner to determine the cause of death of various types of deaths as defined in the statute. These would be deaths that had some element of public interest. Deaths that are pretty obvious from the standpoint of government interest, homicides, accidents, suicides.

And then there were other deaths, sudden deaths not caused by readily recognized disease, people who were not under medical care who die suddenly.

They even have a provision in the law that if the body is to be cremated, the medical examiner had to review the record and be responsible to make sure that what was put on the death certificate by the attending physician was reasonably correct. And so, that was the statutory duty.

Of course, then there were a lot of other duties that arose, because when you're dealing with deaths, there's many problems that occur, and we're expected to assist and help people in solving their problems that arise out of a sudden death. Then we have other things that arise. There was court duty,

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because many of these were homicides. And the duties were quite varied over the years.

Q. And in connection with investigating the cause of death, particularly with respect to homicides, murder cases, I assume you're very familiar with this particular courtroom and the courthouse, and the building, because you would have been called upon to testify in those cases?

A. Yes. This was -- when I first started in Dade County, this is the only courtroom in which any major felony crime, including homicide, was heard and tried back in those days.

Q. In this very courtroom?

A. This courtroom, without air conditioning, windows wide open and the trains rumbling by. We would stop in the middle of testimony, wait for the train to stop.

Q. That was Judge Ben Willard's courtroom for a number of years?

A. Yes.

Q. Now, in addition to your medical examiner role, you had a relationship to the Miami School of Medicine during that time frame. Tell us about that.

A. Well, both Dr. Durlacher and myself, having been on the faculty of Louisiana State University, part

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of the requirement, before we would accept a transfer here, was an association with the University of Miami. And so when we both arrived, we were given faculty appointments with the University of Miami.

Q. Now, from 1970 to 1979, you were chairman, Medical Examiner's Commission, State of Florida. What was the Medical Examiner's Commission, and what did your duties entail as chairman of that commission?

A. Well, prior to 1970 there was no state-wide medical examiner system. Medical examiner, again, is an office or a person who investigates sudden, unexpected violent death. There were some scattered offices around the state. And due to the fragmentation of the state, the Florida Medical Association started a campaign to create a state-wide medical examiner system. And I was part of that effort.

And in 1970, a new law was -- a law that superseded all of the local laws was passed. And that called for the appointment of an oversight group called the Medical Examiner's Commission, made up of governmental officials and also two medical examiners.

And I was chairman of that group for many years and then stepped down as chairman, but remained as a member until I retired from active duty in the medical examiner's department of Dade County in 1996.

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Q. I notice that in 1971, '72 you were president of the Dade County Medical Association?

A. Yes. I joined the association, served on a number of committees and eventually was elected president that year.

Q. Did the Dade County Medical Association include doctors practicing in Dade County across the board in terms of specialties, general practitioners?

A. Yes.

Q. Now, from 1971 to 1996, you were professor of pathology at the University of Miami School of Medicine. But in terms of your actual teaching responsibilities, how did that work? I mean, did the students come to you at the medical examiner's office? Did you teach in a class? Did you demonstrate? How did that work?

A. It varied over the years. Initially when we first started out, medical school curricula, the way students were taught was different than it is today. So I had responsibility for furnishing formal lectures to the senior class back in the early days.

Then, later, it switched over more to the pathology department and became more oriented towards individual lectures. I still, for example, give an annual lecture to the department of pharmacology.

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Students also would rotate through the medical examiner's department. And so they -- the teaching requirements became more fluid, more flexible and diverse. There were joint projects of investigation and study involving members of the faculty at the university in our department.

Q. Although you retired formally as the chief medical examiner in 1996, have you to the present time continued to maintain a relationship with the medical examiner's office?

A. Yes. I have an office there, and I go in about three days a week. And also I have another office I've established at home. So I'm staying quite busy.

Q. I think that people not in the medical field, when they hear the word autopsy, they have a picture of what an autopsy entails. But describe what an autopsy means, in general terms.

A. Basically an autopsy is an examination of a body to determine certain things. It consists of both an external examination, looking at the surface of the body, looking for anything on the surface that may be of relevance to the cause of death or the disease process or injury process the person may have had.

And then there is an opening of the body,

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including the chest and abdomen, neck area and also the head. The opening procedures are done so that later, when it's closed, the body, as prepared by the funeral director, there's no sign that this procedure has been done. But it does permit an examination of the various critical organs of the body in detail including brain, the neck viscera, the organs in the neck, the chest organs, heart, lungs and so forth and the abdomen, liver, spleen, kidneys, the stomach, intestines and the genitourinary tract, all of this can be done through these incisions.

Q. Now, in addition to the observations you're making with the naked eye, so to speak, as you're performing the autopsy, do you do microscopic studies? Is there additional testing that you might do on particular organs if you were particularly interested in learning a certain thing?

A. Yes. Microscopic sections just mean that we take a portion of that particular organ and it's then chemically treated and stained and placed on a glass slide. And it's so thin as to be almost invisible, light will pass readily through it.

Then the different individual cells can be examined. The cells, being the building blocks of tissue, can be examined under the microscope. It just

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gives us an additional confirmation of what we can see and helps us to differentiate sometimes and clarify sometimes what we're seeing with the naked eye.

Q. During your career as a pathologist and medical examiner, how many autopsies do you figure that you personally have done?

A. Well, when I started my career, I started a book. And every time I did an autopsy, I made a one line entry. And by the time I had retired, that book contained in excess of 10,000 entries where I myself did the actual autopsy, not somebody else did it and I just looked over their shoulder, but where I myself participated in the examination. In excess of 10,000.

Q. Hands-on, personal, Dr. Joseph Davis, 10,000 plus?

A. Yes.

Q. Now, you were district medical examiner, District 11, State of Florida from 1972 to 1996?

A. Yes. Dade County was always a medical examiner district. But when the law was passed in 1970, the state was divided up into 24 districts, some single county, some multi-county. There's one that's combined with another district.

So we have 23 active pathologists in the State of Florida, each one covering a single district.

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Dade County is known as District 11 in the state system.

Q. In the early '70s, you were vice-president of the American Academy of Forensic Sciences. What was the purpose of that organization?

A. The American Academy of Forensic Sciences is an organization that started around 1948. It is an association of about 4,000. There's more than 4,000 members. And these are the people who are involved in crime laboratories, in toxicology laboratories, the pathologists, and do the autopsies, work for coroners or medical examiners. Psychiatrists who are involved in forensic psychiatry, questions of mental competency and so forth.

We even have a jurisprudence section made up of lawyers. And engineers who are involved in the engineering analysis get to do court testimony. Quite a large and varied organization, multi-disciplinary. It gives the member an opportunity to see what other people in the field are doing.

Q. And in the years 1975, '76, you were president of the National Association of Medical Examiners. And how does that organization differ from the American Academy of Forensic Sciences?

A. Well, the American Academy, as I said, is

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made up of people from many disciplines. The National Association of Medical Examiners is made up of the forensic pathologist. So, it's more restrictive. Most of the members of the National Association are also members of the American Academy. In fact, we have joint meetings.

Q. In 1981, '82, you became president of the American Academy of Forensic Sciences?

A. Yes.

Q. Did that position as president, did that require you to travel much?

A. Not too much. We had meetings at our headquarters, which is in Colorado, several meetings there, but for the most part, for the American Academy, our travel is to wherever the annual meeting is being held.

Q. In 1983 and '84, you were president of the Dade County Citizens Safety Council?

A. This was a group of citizens of Dade County representing diverse industries, all of whom had one thing in common and that was better safety for the citizens. Monitoring how -- what needed to be done, both in education and also, say, governmental actions to further and enhance the safety of people in this community.

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Traffic safety, for example, road design, some of the road designs that we see today, the barriers that exist between opposing lines of traffic arose because of the actions of the safety council, the pressure that was placed by the safety council on the road builders or those who supervised the building of roads and so forth.

So, it was quite an active program.

Q. Now, according to your certifications, you're a diplomate of the American Board of Pathology and then there are two subcategories. One of them is pathologic anatomy, which you got in 1956.

Now, what does it mean to be a diplomate of the American Board of Pathology and, in particular, the field of pathologic anatomy?

A. What it means is, one, the person is a physician, has a doctorate degree. And then has spent a number of years in a formal training program. For example, I mentioned I was in the Public Health Service hospitals in Seattle and New Orleans. And in those particular hospitals I was in residency training, learning to be a pathologist. And then, after that, one takes an examination that's given by the American Board of Pathology, and if one passes that examination, then one is certified.

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Like when you go to a specialist in medicine, whether it's a cardiovascular specialist or whether it's an internist or surgeon, what have you, each one of these specialists has been certified, undergone a similar type of certification.

Now, pathologic anatomy is just that part of pathology dealing with changes brought by disease and so forth in the individual, in the patient. The pathological anatomist is the person who reviews the microscopic slides, for example, that are prepared from tissues that the surgeons remove during operation to help confirm what the diagnosis is.

The pathologic anatomist is also the person who performs the autopsies and so forth. So that's the primary certification that I hold in the field of pathology.

The secondary was a forensic pathology. The forensic pathologist goes to additional trainings, takes another examination and then, if passed, becomes certified or they call it diplomate of the board.

And then that means the person has two different certifications. That's basically the background of that.

Q. So you're board certified in the two areas?

A. Yes.

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Q. And you mention here on your C.V., National Board of Medical Examiners?

A. That goes back to the early days of medical school. Years ago when the diverse state, each state having its own licensing, there was a consortium of states that got together and created a whole or a program for evaluation of medical students and granting a certificate to medical students following their first two years, then their four years, then a year after they graduate.

So, a person who has gone through that procedure, then receives a certificate, which is accepted by a good number of states, as a means of getting license to practice medicine in that state without having to go through the individual state examination.

So it's just a means of simplifying the state licensing requirements throughout the United States, especially if a person moves from one state to another.

Q. Let me ask you about some of the honors that you've received during your career.

In April 1981 from the State of Florida House of Representatives Resolution 748, commendation for services performed and accomplishments attained as chief medical examiner of Dade County. Tell us what

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you can recall about that award.

A. Well, I got a piece of paper. Have it hanging on the wall at home. It was -- I don't know how it came about --

Q. Is it framed?

A. It's framed.

Q. Not just with a thumb tack?

A. I think it probably arose from not only the job I was doing in Dade County, but I helped and participated in a fair number of legislative problems pertaining to safety and public need. And so I became somewhat familiar with the legislative process in Tallahassee. I guess it came from that. I don't really know how it came about. But it appeared one day.

Q. July 1988 the American Society of Public Administrators, and you were selected as public administrator of the year?

MR. MOSS: Your Honor, Dr. Davis is someone that at least I know for a long time. He's got all kinds of awards, and we'll stipulate to that, and very deservedly. So, if that would move this on --

THE COURT: May cut things down a little.

MR. ROSENBLATT: That's fine.

BY MR. ROSENBLATT:

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Q. Let me ask you, Dr. Davis, about your military service. When you were with the United States Public Health Service, you were actually in the status of a commissioned officer; is that correct?

A. Yes.

Q. You were also a private in the United States Army during World War II for three years?

A. Yes. Three years or four, yes, I guess it was three years.

Q. During your service as a private in the United States Army during World War II did you get free cigarettes in your K-rations?

MR. MOSS: Objection, Your Honor.

THE COURT: All right. Sustained.

MR. ROSENBLATT: I'm a little confused, Judge.

THE COURT: Let's sidebar.

(The following proceedings were had at sidebar:)

MR. MOSS: The basis of our objection is this man, number one, the fact that he got free cigarettes or didn't is not relevant or material to the issues in this case.

Number two, he has not been called as a fact witness. He is here as an expert witness, and I'll

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show you his disclosure.

THE COURT: I read it.

MR. MOSS: It's very, very clear that he's been called as a pathologist. And what Your Honor doesn't know, I'll cite you his deposition: The only thing I know why he's calling me is to comment upon what I've done as a pathologist in looking at lung cancer.

MR. ROSENBLATT: I think that's an overly narrow view on his C.V. Talks about his service in World War II. Obviously I'm not dwelling on this.

The reason I was confused, Judge, you know, you sustained the objection, so my next question was going to be, was it commonly contained with the K-rations in World War II?

MR. MOSS: Same thing, Judge.

THE COURT: Nothing to do with his testimony as an expert pathologist.

MR. ROSENBLATT: While we're up here, Mr. Heim and I were discussing, this is the only other witness I have for today. You're cross examining him, Ed?

MR. MOSS: Depends. I may not have any cross examination.

MR. ROSENBLATT: I'm saying in terms of how

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long of a lunch recess.

THE COURT: It's ten to twelve. What are you talking about, lunch?

MR. ROSENBLATT: The issue is in terms of how long of a recess. It may be an early day.

MR. MOSS: Okay. He's the last witness.

MR. ROSENBLATT: I intend to -- I would like to publish exhibits, but I want to give you the general idea.

THE COURT: If you want to put him on and you can do that and he's going to be finished for the day in a reasonable time, say between now and 1:00 --

MR. ROSENBLATT: No.

THE COURT: He's going to be beyond that.

MR. ROSENBLATT: I would think so.

THE COURT: Then we can break for lunch after the curriculum, then pick up --

MR. MOSS: How much do you have after break?

MR. ROSENBLATT: It's hard to say.

MR. MOSS: Why don't we go, because I'm not going to have much on cross.

MR. HEIM: The only comment I'd make is, to the extent counsel wants to publish exhibits, if they've been admitted already and the entire exhibit is being published, that's one thing. But if he only

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intends to publish part, we need an opportunity to do completeness designations, as you know.

MR. ROSENBLATT: What I would be talking about today is items already in evidence.

THE COURT: If what?

MR. ROSENBLATT: If I publish exhibits today, I'll be talking about exhibits that are admitted.

MR. HEIM: But even if they're admitted.

MR. MOSS: Can't we deal with that later? Only because the witness is sitting here.

THE COURT: Well, I really don't know where he's going. Let's assume he's got a 15-page document and it's admitted and he wants to read Page 9, Paragraph 3. You're entitled to read what is pertinent to that particular part or any other part of it, I suppose, as relevant and material to his testimony. But you ought to know by now after taking his deposition.

MR. MOSS: This is your pretrial.

THE COURT: What did I say?

MR. MOSS: Let us know three days in advance so we can go over this.

MR. ROSENBLATT: We let you know on Friday.

THE COURT: So, you know basically what he's going to testify about. Let's continue.

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MR. ROSENBLATT: My suggestion would be that we would break at the normal hour, let the jury go to lunch, we'd come back, whatever.

MR. MOSS: We'll see where we go. If this jury is going to get off, it would be totally unfair to bring them back.

THE COURT: They don't care.

(The sidebar conference was concluded, and the following proceedings were held in open court:)

BY MR. ROSENBLATT:

Q. Dr. Davis, the jury has already heard from a variety of medical experts, so they're familiar with the bibliography which is attached to a curriculum vitae, which are articles that you've had published in various medical journals. And I want to ask you about a few of them.

The title of one of your articles is, Three Fatal Anaphylactic Reactions Caused By Penicillin, which was published in the Journal Florida Medical Association.

Could you please tell us, Doctor, the thrust of that article?

MR. MOSS: Your Honor, the only objection we have is relevance. I've already said this is an eminently qualified pathologist. The fact that he

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wrote about anaphylactic shock, unless it has relationship to what we're doing it.

MR. ROSENBLATT: Well, that kind of speaking objection --

THE COURT: Let's not talk. It takes two people to acknowledge a stipulation. If there isn't two people acknowledging the stipulation, then we don't have one.

If he wants to go ahead and establish the credibility of the witness and the background, experience and expertise, he has a right to do so. I would like to keep that part of it that's material within the realm of what we're talking about.

Those matters which really don't relate, I guess we could gloss over them.

MR. MOSS: My objection was to relevancy when we're talking about anaphylactic reactions from penicillin.

THE COURT: That's fine. He may be expert in a lot of different fields. When we get down to the ones we're talking about here, we can devote more time. Just enumerate those that he may have done and move on.

BY MR. ROSENBLATT:

Q. Doctor, what was the thrust of the Three Fatal Anaphylactic Reactions Caused By Penicillin?

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A. Well, the main thrust of that was to demonstrate that rarely there are people that die from penicillin that the mechanism of death is not easily or readily discernible at autopsy. One has to do a very careful, meticulous study of particularly the respiratory tract. And that's basically what I recall from that article from many years ago.

Q. As the medical examiner of Dade County, was one of your areas in general how to prevent untimely deaths and safety in general?

A. Yes. That's -- the cases that we see usually involve something that's unfortunate and sudden that's happened to somebody or unexpected. And there's lessons to be learned from these that may be useful in coming up with various programs to prevent such things in the future. So that's one of the main thrusts that we have in our work, it's education.

Q. And Dr. Davis, another article, the title of which is, and I would think has to do with the lungs, Fatal Underwater Breath Holding in Trained Swimmers.

A. Yes.

Q. What was the thrust of that article?

A. The thrust was that there are what is considered rather mysterious deaths, a trained swimmer drowns in calm water and a trained athletic swimmer

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drowning in calm water shouldn't drown, but they do.

And it was due to the physiologic effects of holding the breath and exercise under water and actually what happens is the oxygen level of the blood through their training, they're able to withstand the discomfort and their oxygen level drops below the level of consciousness.

In the meantime, their carbon dioxide in their blood has not risen to the point where it forces them to become very uncomfortable. Carbon dioxide stimulates the brain to cause respiration.

So, this imbalance occasioned by their training can sometimes lead to an untimely death. And we had some of those deaths many years ago. And they were a puzzle at first until I got into it and figured out, through the help of the literature, published literature, what was actually going on.

Q. Another article, Doctor, is Dangerous Drugs, Barbiturate Fatalities in a Metropolitan County -- in a Metropolitan Community.

What was the thrust of that article about these various drugs and barbiturates?

MR. MOSS: We, once again, object on relevance.

THE COURT: Overrule at this point. We'll

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run through these things.

Don't spend too much time.

MR. ROSENBLATT: I'm not going to spend too much time.

THE WITNESS: The main problem with that is we had a problem in the community with drugs, particularly the sedative drugs which would cause death, at least I saw the death results and they died from depreciation of the respiratory center of the brain. And when their respiration failed, they died from a result of the misuse of the drug. It was quite a serious problem that I could see in the community, so that was the thrust of that particular article.

BY MR. ROSENBLATT:

Q. You've done a number of articles on poison deaths?

A. Yes.

Q. You did an article the title of which is, Autopsy Findings in Victims of Drowning. Did that -- did you, in that article, deal specifically with how the function of the lungs and the reaction of the lungs in terms of drowning deaths?

A. It touches on that, yes, because the lungs are a focal point of study in a death by drowning.

Q. You've done articles on narcotic addiction

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and overdoses leading to death?

A. Yes.

Q. Now, there's an item on your curriculum vitae the title of which is, Cigarettes and Death Certificates.

What did that involve?

A. Well, actually, that was a good number of years ago, and it dealt with an opinion I had that death certificates should be modified to ask the question as to smoking history. If the doctor is going to put down a cause of death on the death certificate, the public health interest in tobacco was quite extensive at that time, it still is, and this is a way for the people who study the data of death certificates to gain a better insight in the diseases that they're studying from the death certificate.

For example, a death certificate might put on there pulmonary emphysema, but then there's nothing else on the death certificate that the attending physician wrote to indicate what caused the pulmonary emphysema. And by collecting additional data, this becomes useful to the people who are looking at health trends and ways of changing ill health.

That's the purpose, really, of a death certificate. Death certificate, as far as the medical

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entry, its only value is to allow us to look at what's going on in society and then come up with programs to help improve our life.

Q. Was that recommendation by you ever effectuated, ever carried out?

A. Not in this state, no.

Q. Will it sometimes say on a death certificate that the cause of death, for example, is lung cancer?

A. That's true.

Q. Does the death certificate provide for a space as to what was the cause of the lung cancer?

A. No, it does not.

Q. Is that one of the reasons you wanted that information to be included about the smoking history?

A. Yes.

Q. You did an article, the title of which is -- you did this in 1987 -- The Relationship Between Russian Roulette Deaths and Risk-Taking Behavior, a Controlled Study.

Did that controlled study involve a study also of the risk-taking behavior of young people.

A. Well, that was implicit in the subject matter. Because this is a form of human behavior we've seen covering a range of ages, but it's usually a younger male.

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Q. So what, in fact, did you find as a result of your research -- what was the relationship between Russian Roulette deaths and risk-taking behavior among young males?

A. It was an example of extreme amount of risk taking and the conclusion was also that some of these people lack controls in terms of being concerned about their own livelihood and their own well being. Some people are impulsive. And this type of behavior usually appears in those types of people with that type of personality.

Q. Well, I won't ask you your, to explain in any detail, you did write an article about the crash of the Value Jet flight and deaths related to Hurricane Andrew?

A. Yes.

MR. ROSENBLATT: Your Honor, I've reached the stage where I've basically finished with Dr. Davis's curriculum vitae. I would suggest that this is a good time to break for lunch. And I'll complete my direct after that.

THE COURT: Let's to do that. Let's take our lunch break at this point. Come back an hour and fifteen minutes as usual. It's 12:00. Come back at quarter after one, and we'll finish up.

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(The jurors exited the courtroom.)

THE COURT: So, after lunch, you'll go on with your direct, then we'll have cross and finish up with this witness, and that will probably be it for the day, I guess.

MR. ROSENBLATT: Or I may after lunch, Judge, be in a position to say the documents that I would like to read from.

THE COURT: Maybe we can take up the time doing something, recording some of the documents.

MR. MOSS: Your Honor, would you instruct Dr. Davis, I know he knows it, but he's not supposed to be talking to any, including plaintiffs', lawyers about this case.

THE COURT: Yes.

(A lunch recess was taken at 12:00 p.m.)

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